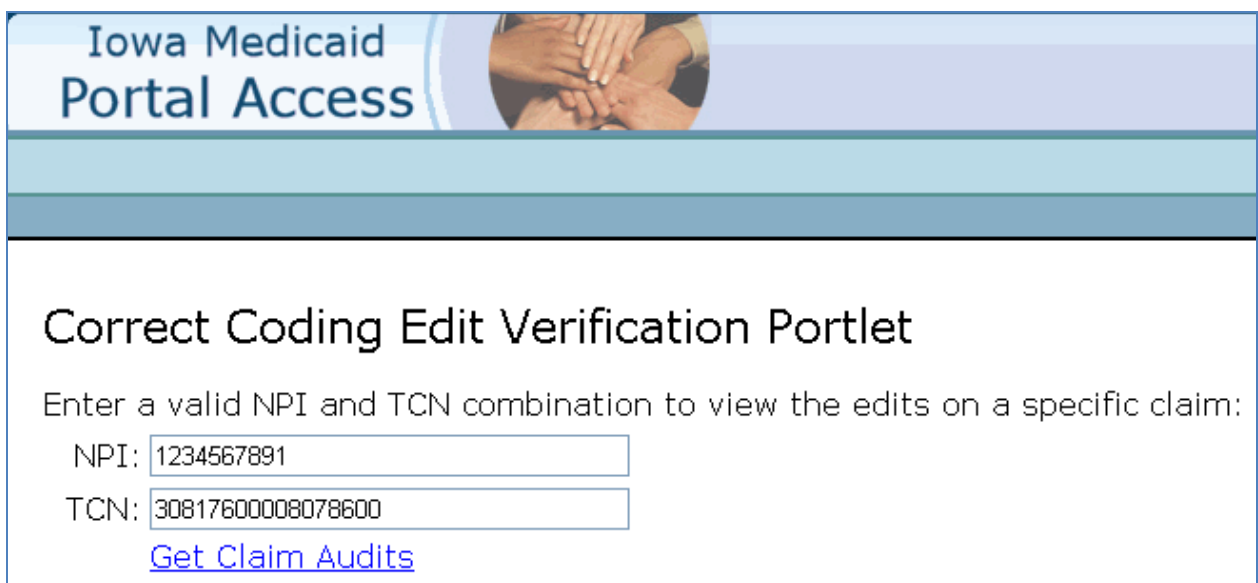


## Logging on to the Correct Coding Edit Verification Portlet

- 1) Go to <https://secureapp.dhs.state.ia.us/imp/review/bloodhound.aspx>
- 2) Enter the NPI (National Provider Identifier) of the billing provider as submitted on the claim
- 3) Enter the 17 digit TCN (Transaction Control Number) of the claim (do not enter spaces or dashes). The TCN is assigned by the Iowa Medicaid Enterprise (IME) and is referenced on the Remittance Advice statement.
- 4) Click on “Get Claim Audits”



The screenshot shows the Iowa Medicaid Portal Access interface. At the top, there is a header with the text "Iowa Medicaid Portal Access" and a small image of hands stacked together. Below the header, the main content area is titled "Correct Coding Edit Verification Portlet". Under this title, there is a prompt: "Enter a valid NPI and TCN combination to view the edits on a specific claim:". Below the prompt, there are two input fields. The first field is labeled "NPI:" and contains the value "1234567891". The second field is labeled "TCN:" and contains the value "30817600008078600". Below the TCN field, there is a blue hyperlink that says "Get Claim Audits".

**\*Reminder to providers-** this portlet is only for use when claims include denials with the following EOB codes:

For the standard IME Remittance Advice:

**750,848,849,850,851,852,853,854,855,856,857,858,859,860**

For the HIPAA 835 electronic remittance advice from EDISS:

**125**

**The audits will appear as shown in the example below:**

Audit 1

A

B

E/M[E/M Crosswalk | Intra-range

The e/m services described by 99285 and 99284 on the same day by the same provider are not allowed, therefore 99284 is not reimbursable.

Details

C	Claim Number	Line	HCPCS	Modifier	Units	Creation Source	Role in Audit	Action
	30817600008078600	00001	99284		1	Submitted on Claim	Action Required	Not Reimbursable
	50903066005000100	00001	99285		1	Submitted on Claim	Considered in Determination	None

Sources

D

**Center for Medicare Services | National Correct Coding Policy Manual**  
*Effective from 01/01/2003 through current*  

CPT codes for evaluation and management services are principally included in the group of CPT codes, 99201-99499. The codes are divided to describe the place of service (eg. Office, hospital, home, nursing facility, emergency department, critical care, etc.) the type of service (e.g. new or initial encounter, follow-up or subsequent encounter, consultation, etc.) and various miscellaneous services (e.g. prolonged physician service, care plan oversight service, etc.). Because of the nature of evaluation and management services, which mostly represent cognitive services (medical decision making) based on history and examination, correct coding primarily involves determination of the level of history, examination and medical decision making that was performed rather than reporting multiple codes. Only one evaluation and management service code may be reported per day."

**Center for Medicare Services | National Correct Coding Policy Manual**  
*Effective from 01/01/2003 through current*  

CPT codes for evaluation and management services are principally included in the group of CPT codes, 99201-99499. The codes are divided to describe the place of service (eg. Office, hospital, home, nursing facility, emergency department, critical care, etc.) the type of service (e.g. new or initial encounter, follow-up or subsequent encounter, consultation, etc.) and various miscellaneous services (e.g. prolonged physician service, care plan oversight service, etc.). Because of the nature of evaluation and management services, which mostly represent cognitive services (medical decision making) based on history and examination, correct coding primarily involves determination of the level of history, examination and medical decision making that was performed rather than reporting multiple codes. Only one evaluation and management service code may be reported per day."

**Center for Medicare Services | National Correct Coding Policy Manual**  
*Effective from 01/01/2003 through current*  

CPT codes for evaluation and management services are principally included in the group of CPT codes, 99201-99499. The codes are divided to describe the place of service (eg. Office, hospital, home, nursing facility, emergency department, critical care, etc.) the type of service (e.g. new or initial encounter, follow-up or subsequent encounter, consultation, etc.) and various miscellaneous services (e.g. prolonged physician service, care plan oversight service, etc.). Because of the nature of evaluation and management services, which mostly represent cognitive services (medical decision making) based on history and examination, correct coding primarily involves determination of the level of history, examination and medical decision making that was performed rather than reporting multiple codes. Only one evaluation and management service code may be reported per day."

**A.** The rule-category that fired this audit. This will be a hierarchical representation of the modules and sub categories for the rule. There can be up to five (5) levels on a claim. (See attachment **1A** for detailed explanation for each of the following rule categories.)

- **Multiple Surgeons**
- **Add On**
- **CCI- Correct Coding Initiative**
- **Age/Gender**
- **Duplicates**
- **E/M- Evaluation and Management**
- **GSP- Global Surgical Package**
- **Incidental Procedures**
- **Medical Necessity**

**B.** The audit description, or audit text. This is a complete statement of the audit, including the actual procedure codes involved.

**C.** Audit Details

- **Claim number-** the 17 digit TCN
- **Line-** the line number on the claim that is involved
- **HCPCS-** (Healthcare Common Procedure Coding system) procedure code billed on claim
- **Modifier-** modifier billed with procedure code on claim
- **Units-** the number of units billed on claim
- **Creation Source-** shows if claim line was submitted by the provider or added by the IME
  - **Submitted on Claim-** sent in by provider
  - **Created by Edit-** when a code was replaced by IME (see the action “Add”)

- **Role in Audit-** Action to take on line
  - **Action Required-** see list of actions below
  - **Considered in Determination-** no action to take on this claim line for this audit, but this claim line was involved in an audit
- **Action-** The decision of claim payment
  - **Not reimbursable-** will not be paid
  - **None-** will be paid
  - **Replace-** will not be paid, code is being replaced by another procedure code (see “**Add**”)
  - **Add-** a line added by IME to replace a line submitted on the claim by the provider
  - **Pay at X%-** when “X” is the percentage of the claim that should be paid

#### **D. Sources**

The professional resources used in determining the audit finding such as the AMA (American Medical Association), CPT (Current Procedural Terminology), CMS (Center for Medicare and Medicaid Services), and professional medical association recommendations.